United Nations E/2013/62

Economic and Social Council

Distr.: General
6 May 2013

Original: English

Substantive session of 2013
Geneva, 1-26 July 2013
Item 7 (e) of the provisional agenda*
Coordination, programme and other questions

Joint United Nations Programme on HIV/AIDS (UNAIDS)

Note by the Secretary-General

The Secretary-General has the honour to transmit to the Economic and Social Council the report of the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), prepared pursuant to Council resolution 2011/19.

* E/2013/100.

13-32456 (E) 280513

Please recycle

Report of the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS)

Summary

The present report was prepared in response to Economic and Social Council resolution 2011/19, in which the Council requested the Secretary-General to transmit, at the substantive session of 2013, a report prepared by the Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), in collaboration with its co-sponsors and other relevant organizations and bodies of the United Nations system, on progress made in implementing a coordinated response by the United Nations system to the HIV/AIDS epidemic.

We stand at a critical moment in the world's more than three-decades-long effort to address the historic challenge posed by HIV. There is good news. The number of new HIV infections in 2011 was 20 per cent lower than in 2001, the number of children who acquired HIV infection declined by 24 per cent from 2009 to 2011, and AIDS-related deaths in 2011 were 24 per cent lower than in 2005. Since 1995, antiretroviral therapy has added 14 million life-years in low- and middle-income countries. Powerful new tools have emerged to prevent new infections, including antiretroviral treatment for HIV prevention and voluntary medical male circumcision. Buoyed by the promise of research breakthroughs and by the progress that has been achieved, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has promoted a vision: zero new HIV infections, zero discrimination and zero AIDS-related deaths.

Yet, while optimism has never been greater in the history of the AIDS response, nor more warranted, critical challenges remain. New infections are on the rise in many countries and regions, and HIV prevention efforts are inadequately resourced and insufficiently implemented. Although 8 million people in low- and middle-income countries received antiretroviral treatment in 2011, nearly half of all people eligible for treatment did not receive it, and many individuals who initiate treatment do not remain in care. Achieving the three zeros will be impossible without dramatically stronger commitment to evidence- and human rights-based and gender-transformative approaches that address the needs of young people and key populations, including men who have sex with men, transgender people, people who use drugs, and sex workers, as well as the intimate partners of those groups. While funding for HIV activities in low- and middle-income countries rose in 2011, including through increased domestic investments, substantially greater resources will be needed to reach those who currently lack access to essential services, and plans must be put in place to ensure long-term sustainability of the response.

In 2011, the General Assembly adopted the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV/AIDS (resolution 65/277), which set forth a series of concrete targets to be achieved by 2015. The Political Declaration aims to accelerate progress towards universal access to HIV prevention, treatment, care and support and to support achievement of Millennium Development Goal 6, which calls for concerted global action to halt and begin to reverse the epidemic by 2015. Recognizing also the links between HIV and security, the Security Council, in resolution 1983 (2011), called for incorporation of HIV-specific strategies and programmes in United Nations peacekeeping missions. While major

progress has been made towards reversing the epidemic, Goal 6 has not been reached, especially in the many countries where prevention efforts lag and where antiretroviral treatment has yet to be brought to scale.

As the only jointly co-sponsored programme within the United Nations system, UNAIDS combines the efforts of 11 co-sponsors (International Labour Organization, United Nations Development Programme, United Nations Educational, Scientific and Cultural Organization, United Nations Population Fund, Office of the United Nations High Commissioner for Refugees, United Nations Children's Fund, United Nations Office on Drugs and Crime, UN-Women, World Food Programme, World Health Organization and the World Bank) and a secretariat under a shared vision and a single budget and results-based framework to focus on AIDS. The Joint Programme's approach, which enhances the coherence, coordination, transparency and strategic impact of United Nations action on HIV at the country level, aligns with and supports General Assembly resolution 67/226, entitled "Quadrennial comprehensive policy review of operational activities for development of the United Nations system".

This report summarizes progress achieved towards 10 key targets based on the 2011 Political Declaration, with a specific focus on contributions by the Joint Programme. In addition to noting the important advances made, it also describes programmatic and policy gaps that slow progress towards those goals.

With the deadline for the 2015 targets rapidly approaching, now is the time for the global community to sustain and scale up the gains made and strengthen its commitment to the response. AIDS must be recognized and embraced as a shared responsibility, necessitating reinvigorated action, international solidarity and strategic focus. The AIDS resource gap must be closed, and all stakeholders must recommit to use evidence and human rights principles to guide future actions.

I. Update on the epidemic

1. AIDS remains one of the world's most serious health, development and human rights challenges. At the end of 2011, an estimated 34.0 million people were living with HIV worldwide. With about 5.0 per cent of its residents estimated to be living with HIV, sub-Saharan Africa remains the region most heavily affected by the epidemic, accounting for 71 per cent of new infections in 2011. Next to sub-Saharan Africa, the Caribbean (1.0 per cent) and Eastern Europe and Central Asia (1.0 per cent) have the highest estimated regional prevalence. There is considerable variation within and among countries and regions with respect to HIV prevalence, epidemiological patterns and the evolution of the epidemic.

2. The number of people (adults and children) newly infected with HIV in 2011 (2.5 million) was 20 per cent lower than in 2001. Progress has been especially noteworthy among children, with 24 per cent fewer children newly infected with HIV in 2011 (330,000) than in 2009 (430,000). As access to antiretroviral therapy has expanded, with coverage of 54 per cent in 2011 under current treatment guidelines, the number of AIDS-related deaths in 2011 (1.7 million) was 24 per cent lower than in 2005. Since 2004, tuberculosis-related deaths among people living with HIV have declined by 25 per cent globally and by 28 per cent in sub-Saharan Africa.

3. In 2011, women accounted for 49 per cent of all adults living with HIV worldwide and for 58 per cent in sub-Saharan Africa. Globally, one young woman is newly infected every minute, and young women in sub-Saharan Africa are more than twice as likely as young men their own age to be living with HIV. Although HIV prevalence among young people (aged 15-24) fell globally by nearly 27 per cent from 2001 to 2011, the epidemic continues to have considerable impact on young people, who account for 14 per cent of all people living with HIV and 39 per cent of new infections.

4. While new infections fell by 42 per cent in the Caribbean and by 25 per cent in sub-Saharan Africa from 2001 to 2011, new infections are increasing in Eastern Europe and Central Asia and in the Middle East and North Africa, as well as in a number of countries in Asia. From 2005 to 2011, AIDS-related mortality rose by 21 per cent in Eastern Europe and Central Asia and by 17 per cent in the Middle East and North Africa.

5. Certain key populations are much more heavily affected by the epidemic than the general population. According to surveys, female sex workers are on average 13.5 times more likely than other women to be living with HIV. The prevalence of HIV is 22 times higher among people who inject drugs than for the population as a whole, and 19 times higher for men who have sex with men than for men generally. Data on transgender people is severely limited, although available evidence indicates extremely high HIV prevalence.

6. While global trends are encouraging, AIDS is far from over. AIDS remains the leading cause of death among women aged 15 to 49 years worldwide, the leading cause of life-years lost in Southern and Eastern Africa, the third leading cause of death in Eastern Europe, and the sixth leading cause of death worldwide. As of December 2011, 17.3 million children in the world had lost one or both parents to AIDS.

II. The Joint United Nations Programme on HIV/AIDS (UNAIDS)

7. To provide leadership in the AIDS response, UNAIDS draws on the experience and expertise of 11 co-sponsors and a largely field-based secretariat, with two thirds of its staff deployed in more than 90 regional and country offices. At the country level, UNAIDS operates through Joint United Nations Teams and Joint Programmes of Support, which promote coherent and effective United Nations action in support of an effective national AIDS response, under the leadership of the United Nations Resident Coordinator. UNAIDS frequently serves as a model of "Delivering as one" and is supporting the development of the second generation of this United Nations-wide initiative to increase coordination and coherence at all levels.

8. As the epidemic has evolved, so has UNAIDS, adding UN-Women as the eleventh co-sponsor in 2012, taking steps to enhance accountability for results, and undertaking focused streams of work to accelerate progress towards the 2015 targets. UNAIDS has repositioned its resources, reallocating human and financial resources from global to regional and country levels and prioritizing countries most heavily affected by the epidemic.

A. Getting to zero: the UNAIDS Strategy 2011-2015, the 2011 Political Declaration and Security Council resolution 1983 (2011)

9. To advance the vision of a world with zero new HIV infections, zero discrimination and zero AIDS-related deaths, UNAIDS put in place a five-year strategy for 2011-2015 that provides a framework for the Joint Programme's work. With the aim of galvanizing a transformation in the response, the UNAIDS Strategy has three strategic directions: to revolutionize HIV prevention; to catalyse the next phase of treatment, care and support; and to advance human rights and gender equality in the response.

10. Under the Strategy, UNAIDS has established specific goals for 2015, which align with those in the 2011 Political Declaration. Recognizing that the key test of the Joint Programme's success is achieving real results in countries, UNAIDS has identified 38 high-impact countries in which it has intensified its focus to accelerate progress in "getting to zero". UNAIDS advocacy is emphasizing the shared responsibility of the AIDS response, urging all stakeholders to redouble their efforts and renew their commitment to accelerate progress.

11. In accordance with the mandate of Security Council resolution 1983 (2011), the Joint Programme Department of Peacekeeping Operations collaboration on AIDS in several conflict and post-conflict countries has forged strong working partnerships with peacekeeping missions, including in three priority areas: sexual and gender-based violence; disarmament, demobilization and reintegration; and security sector reform. For example, in the Democratic Republic of the Congo comprehensive sexual and gender-based violence training has been implemented, and subsequently military trainers of the country's Armed Forces, Forces Armées de la République Démocratique du Congo (FARDC), have provided sexual and gender-based violence sensitivity training to 2,000 FARDC soldiers with the aim of affecting attitudes and social norms of the 120,000 FARDC soldiers. In South Sudan, UNAIDS has been supporting the roll-out of HIV and sexual and gender-

based violence sensitization programming to local communities, with increasing utilization of United Nations Mission in the Republic of South Sudan (UNMISS)-supported voluntary counselling and testing services and provision of services for HIV post-exposure prophylaxis for rape survivors.

B. Delivering as one

12. In line with the Paris Declaration on Aid Effectiveness, the Accra Agenda for Action and the Busan Partnership for Effective Development Cooperation, UNAIDS prioritizes coherence, coordination and delivering as one at country, regional and global levels. In 2013, UNAIDS launched a process to assess policies and practices against actions recommended by the General Assembly in resolution 67/226, entitled "quadrennial comprehensive policy review of operational activities for development of the United Nations system". As a pioneering instrument designed to promote the coherence, efficiency, effectiveness and accountability of United Nations efforts to address HIV, UNAIDS is well placed to offer concrete experience in implementing resolution 67/226, including the Joint Programme's success in focusing on results, lowering transaction costs and streamlining procedures.

13. Since 2005, UNAIDS has adhered to a division of labour among the secretariat and co-sponsors for the delivery of technical support. Following the Second Independent Evaluation of UNAIDS, which called on the Joint Programme to take steps to be more "focused, strategic, flexible and responsive, efficient and accountable", UNAIDS, beginning in 2009, undertook a comprehensive review of experience with the division of labour. In particular, the Joint Programme examined ways to better define roles and responsibilities and to operationalize work in cross-cutting areas such as gender and human rights. The revised approach, adopted in 2010, replaced the previous division of labour with an approach that facilitates collaboration towards priority objectives. The revised division of labour consolidates UNAIDS support to countries in 15 areas of work, with one or two agencies specified as conveners responsible for facilitating collaboration within each area. This approach not only enhances the coherence, coordination and impact of UNAIDS efforts at the country level, but increases the transparency of the Joint Programme's work at the country level and alerts diverse stakeholders to optimal entry points.

14. UNAIDS has intensified its efforts to maximize the strategic impact of its assistance to countries. Within countries, UNAIDS Country Coordinators work within the Resident Coordinator system to advance the work of the United Nations country team. UNAIDS has adopted innovative organizational and strategic arrangements to strengthen the effectiveness and coordination of the United Nations system's efforts in countries. Joint United Nations Teams on AIDS, which are in place in 86 countries, provide a platform for communication and coordination among all United Nations agencies engaged in HIV-related activities at the country level. In many countries, these joint teams have been expanded to include non-United Nations partners, contributing to broader efforts to enhance the coordination and impact of national AIDS responses. In 69 countries, United Nations partners have implemented Joint United Nations Programmes of Support on AIDS, thus integrating the entirety of the United Nations system's support for the national AIDS response.

C. Accountability

15. The Unified Budget, Results and Accountability Framework is a unique accountability instrument within the United Nations system, mobilizing and focusing the contributions of 11 co-sponsors and the secretariat to achieve common specific results towards the targets and elimination commitments in the 2011 Political Declaration. The Framework is the key vehicle for operationalizing the UNAIDS Strategy 2011-2015 and for holding the UNAIDS family accountable for results. It maximizes the coherence, coordination and impact of the United Nations response to AIDS by combining the efforts of co-sponsors and the secretariat in a single strategic, results-driven framework. Developed in partnership with diverse stakeholders from all regions, the Framework catalyses and leverages resources for the AIDS response as well as broader health, development and human rights outcomes.

16. The Unified Budget, Results and Accountability Framework clearly links results of the Joint Programme with global targets, providing the whole of the results chain from inputs through impact. A series of output and outcome indicators, linked to achievement of the strategic outcomes set forth in the 2011 Political Declaration, have been developed to promote accountability within the Joint Programme, with annual performance reviews undertaken to assess progress. The Framework specifies individual co-sponsor contributions and expected outcomes, using a division of labour that leverages respective co-sponsor and secretariat expertise and comparative advantages. The Framework provides transparent explanation of how the individual contributions of co-sponsors and the secretariat function synergistically to achieve broad-based results.

17. Baselines and targets on core Unified Budget, Results and Accountability Framework indicators form the basis against which progress in implementing United Nations Joint Programmes of Support are measured. With flexibility to enable core indicators to be selected based on national contexts and epidemic profiles, Joint United Nations Teams on AIDS report on the outcomes and outputs relevant to their settings. The review of results against country targets offers the Joint Teams the opportunity to improve performance in order to strengthen existing systems and build capacity.

18. In 2012, UNAIDS launched the Joint Programme Monitoring System, an innovative instrument for reporting country-level results. The System is a web-based tool to monitor the performance and results of UNAIDS and enable the Joint Programme to make adjustments based on performance information. It allows for collection of detailed results from all countries. Indicator reporting is complemented by thematic reporting, which provides a fuller picture of the contribution of individual co-sponsors and the secretariat and the Joint Programme as a whole towards specific outcomes. The Unified Budget, Results and Accountability Framework effectively implements the key requirements and principles of the quadrennial comprehensive policy review, focusing on results-based planning and budgeting, accountability for results, strengthened joint work, enhanced effectiveness, transparency and system coherence. Over time transaction costs are being reduced.

19. Performance monitoring of the Joint Programme has been further strengthened by a series of external assessments of UNAIDS performance. In 2012, the Multilateral Organization Performance Assessment Network, a network of 17 donor

countries, positively assessed UNAIDS performance, citing the Joint Programme's technical expertise, recognized value to partners, consultative approach and partnership cultivation, in particular in relation to civil society. Similar strengths were noted in performance assessments of UNAIDS undertaken by Australia and the United Kingdom of Great Britain and Northern Ireland, along with other steps, including cost-cutting measures undertaken by the Joint Programme, the strong emphasis of UNAIDS on gender and other key issues, and its strategic leadership in advocacy and coordination. Independent reviews also recommended additional steps to buttress the Joint Programme's performance management system, including better linking results with investments; ensuring that all plans and strategies have clear targets, baselines and milestones; scaling up technical leadership; and strengthening partnerships beyond co-sponsors.

20. UNAIDS has strengthened its financial management accountability and reporting through the secretariat's implementation of the International Public Sector Accounting Standards (IPSAS), a set of accounting standards used by public sector agencies worldwide in preparation of financial statements. Implementation of IPSAS has strengthened UNAIDS accountability to donors, provided comprehensive information on costs, improved accounting for income and expenditure, strengthened monitoring of revenue and expenses, enhanced transparency and harmonization of UNAIDS financial reports and statements with those across the broader United Nations system, and improved the consistency and comparability of financial information. Training of staff, including in country offices, has increased awareness of the Joint Programme's business and financial processes and clarified roles and responsibilities for financial management. The external auditors issued an unqualified audit opinion on the financial statements of UNAIDS for 2012.

D. Partnership

21. UNAIDS is a visionary partnership, uniting under a single umbrella the HIV-related efforts of 11 co-sponsors and the Secretariat. The Joint Programme's commitment to partnership extends much further than the United Nations, recognizing the vital roles played by diverse stakeholders in an effective AIDS response. UNAIDS prioritizes partnerships that contribute to national ownership of the AIDS response, foster South-South cooperation, engage people living with HIV and the communities most heavily affected, and link HIV with the broader health, peace, development, human rights, gender equality and social justice agendas. In 2012, UNAIDS launched a pioneering new strategy to engage young people in the AIDS response, using crowdsourcing technology and new media tools and drawing from the input of more than 5,000 young people in 79 countries.

22. To implement the UNAIDS Strategy 2011-2015, the Joint Programme comprehensively assessed its approach to partnership, with the goal of strengthening strategic partnerships and identifying new partners in moving forward. UNAIDS assists the Global Fund to Fight AIDS, Tuberculosis and Malaria by supporting the Fund's mobilization of new resources, aiding countries in developing sound proposals and implementing approved projects, and providing normative guidance to inform and support Global Fund efforts. In 2012, UNAIDS provided technical contributions to more than 19 grants under review, yielding funding decisions worth US$ 1.9 billion for HIV programmes. As the Global Fund has implemented a new funding model that prioritizes high-impact interventions and support for countries in

greatest need, UNAIDS has actively coordinated the technical support efforts of several major donors for early and interim new applications. UNAIDS works closely with the Global Fund, civil society and other partners to support greater and smarter investments in community systems strengthening and human rights and gender programming. UNAIDS works closely, at global and country levels, with other major providers of HIV assistance, including the United States President's Emergency Plan for AIDS Relief (PEPFAR), helping to maximize the impact of the Emergency Plan's funding and leveraging its support to strengthen health systems.

23. Over the last two years, UNAIDS championed a new, more accountable and systematic approach to partnerships with civil society, applicable across the Joint Programme. The UNAIDS Guidance for partnerships with civil society, including people living with HIV and key populations, was developed through an inclusive, participatory process with inputs from more than 70 civil society representatives in addition to co-sponsor and secretariat colleagues. The UNAIDS Guidance Document 2011 highlights key principles and minimum standards for working with civil society partners and aims to ensure consistency in partnership behaviour across the Joint Programme.

24. The Joint Programme's partnerships with civil society are wide-ranging. In collaboration with the Ecumenical Advocacy Alliance, the Global Network of People Living with HIV (GNP+) and the International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS, UNAIDS has played an active role in systematizing and sustaining dialogue between religious leaders and national networks of people living with HIV. Partnering with people living with HIV, UNAIDS has helped to develop and implement "Positive Health, Dignity and Prevention", a new approach that links HIV prevention and treatment for people living with HIV, situating them within a comprehensive response grounded in human rights. In 2012, UNAIDS established a dialogue platform to ensure ongoing input from women living with HIV and worked alongside 30 of those women to generate the "Women Out Loud" report focused on women's role in advancing progress towards 10 key global AIDS targets.

25. UNAIDS has a track record of transformative partnerships where the private sector has linked up in new ways, sharing responsibility and accountability for results. An example is the Business Leadership Council, launched in Davos in 2012, to galvanize private sector engagement in support of the Global Plan. Council members are a select group of leaders who represent media, finance, telecommunications, health, technology and retail, and who are committed to bring business acumen and resources to the challenge. The Council is focusing on policy shifts, advocacy and financing, and on scaling up support in several priority countries. The Council co-authored, with the Clinton Foundation's HIV/AIDS initiative and the United Nations Children's Fund (UNICEF), a business case to accelerate the debate on this topic, and is exploring how an innovative financing mechanism could be created to bridge some of the financial gaps. The Business Leadership Council also supported the development of a plan for prevention of mother-to-child transmission of HIV at the State and provincial level in Nigeria.

III. Towards the 2015 deadline: results in 10 priority areas

26. The discussion below summarizes progress achieved towards 10 key targets for 2015 and describes the contributions of the Joint Programme towards those global objectives.

A. Reduce sexual transmission of HIV by 50 per cent

27. Declines in HIV incidence — both globally and, most notably, in many high-prevalence countries in sub-Saharan Africa — highlight gains in preventing new infections. In several countries in sub-Saharan Africa, fewer young people are having sex before age 15, multiple partnerships have declined and rates of condom use have increased. However, relatively modest progress has been made in recent years in reducing the annual number of new infections among adults and adolescents, with no meaningful reduction reported since 2008.

28. A number of challenges impede efforts to prevent sexual transmission. In the overwhelming majority of countries with representative surveys (26 of 31 for women and 21 of 25 for men), less than 50 per cent of young people aged 15 to 24 had accurate and comprehensive knowledge about HIV transmission and prevention, with young women and girls typically having lower HIV-related knowledge levels than males their own age. A major condom gap exists, with the international community — the primary purchaser of condoms — supplying only 3.4 billion male condoms and 43.3 million female condoms for distribution in low- and middle-income countries in 2011, far short of the 10 billion needed each year. Voluntary medical male circumcision (VMMC) lowers the risk of female-to-male sexual transmission, but circumcision coverage is below 5 per cent of the target number of men in at least six priority countries, although there are signs that the pace of scale-up may be accelerating.

29. HIV prevention efforts are especially failing to reach those most at risk. Although those populations are substantially more likely than others to acquire HIV, prevention service coverage remains persistently inadequate. While funding for prevention programmes focused on sex workers and men who have sex with men increased from 2006 to 2011 (by 3.7-fold for sex workers, and by 3.2-fold for men who have sex with men), country contributions to those efforts tend to be minimal, with international sources accounting for 91 per cent of total HIV prevention spending for sex workers and 92 per cent for spending on men who have sex with men in 2010-2011.

30. The collective efforts of the UNAIDS co-sponsors and secretariat have contributed to recent HIV prevention gains. Joint United Nations Teams on AIDS assisted 35 countries in translating research on new technologies into implementation and scale-up, and supported 71 countries in managing the procurement and distribution of essential prevention commodities. The Joint Programme oversaw the development of a joint strategic action framework for VMMC and partnered with the United States President's Emergency Plan for AIDS Relief to produce and disseminate 13 country-specific briefs on the latest information on VMMC. UNAIDS strengthened national capacity for sexual and reproductive health services to young people in 82 countries and provided technical support to ministries of education in over 75 countries to strengthen the education sector's AIDS response.

High-level support was secured for the UNAIDS Eastern and Southern Africa Commitment process, which seeks to scale up good quality, age-appropriate, comprehensive sexuality education and sexual and reproductive health services in 21 countries in the region. The Joint Programme, through the leadership of the United Nations Population Fund (UNFPA), is the leading purchaser of female condoms and the third leading purchaser of male condoms, and a new generic specification and pre-qualification guidelines were developed for female condoms.

31. UNAIDS has undertaken extensive efforts to enhance HIV prevention efforts for key populations at higher risk. New training modules were developed and launched to build leadership capacity among young people in key populations in the Asia-Pacific region. New epidemiological and normative guidance documents were produced on HIV prevention among sex workers. The Joint Programme also supported the largest gathering of sex workers ever in connection with the 2012 International Conference on AIDS.

B. Reduce HIV transmission among people who inject drugs by 50 per cent

32. UNAIDS recommends a package of harm reduction strategies to reduce new infections among people who inject drugs. Key components of the harm reduction package include access to sterile needles and syringes, opioid substitution therapy, antiretroviral therapy and other critical health services.

33. Although evidence indicates that scaled-up harm reduction programmes sharply reduce drug-related HIV transmission, service coverage remains extremely low in most settings. Globally, only two needle-syringes were distributed monthly for every person who injected drugs in 2010, with sterile syringes used only in an estimated 5 per cent of drug injection episodes. Legal and policy obstacles — such as compulsory drug treatment or harassment of people who inject drugs by law enforcement officials — undermine the reach and effectiveness of harm reduction programmes. Underfunding by national governments also contributes to suboptimal harm reduction service coverage, with international sources supplying 92 per cent of HIV spending for people who injected drugs in 2010.

34. To expedite progress towards halving new infections among people who inject drugs by 2015, UNAIDS issued guidance for countries to set targets for universal access for people who inject drugs. Policy guidance was produced on implementing a comprehensive package of interventions for HIV prevention, treatment and care in prisons and other closed settings, and comprehensive strategic information was disseminated on the global AIDS epidemic among people who inject drugs. In 2012, the Joint Programme convened a consultative process involving all co-sponsors and the secretariat, which culminated in a historic position paper urging closure of compulsory drug detention centres. In diverse countries and regions, the Joint Programme aided partners in implementing evidence-informed and human rights-based HIV programmes for people who inject drugs and supported capacity development of the International Network of People who Use Drugs.

C. Eliminate new HIV infections among children and substantially reduce AIDS-related maternal and child deaths

35. In 2011, 57 per cent of pregnant women living with HIV worldwide, and 59 per cent in sub-Saharan Africa, received effective antiretroviral regimens for ending mother-to-child transmission. Coverage is substantially lower in South and South-East Asia (18 per cent) and the Middle East and North Africa (7 per cent).

36. In June 2011, UNAIDS convened 22 countries and 30 representatives of civil society, the private sector, networks of people living with HIV and international organizations to develop a road map for achieving the global goal for 2015. The resulting Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive: 2011-2015 calls for four key actions: (a) strengthen primary HIV prevention services for reproductive-age women and their partners; (b) meet the unmet need for family planning among women living with HIV; (c) provide timely HIV testing, counselling and antiretroviral therapy to pregnant women living with HIV to prevent transmission to their children; and (d) deliver HIV care, treatment and support for women living with HIV, children living with HIV and their families. As of December 2012, nearly 100 countries had begun a national roll-out of the strategic framework set forth in the Global Plan, with 738 civil society groups engaged in those efforts.

37. Numerous challenges have emerged in the quest to reach this 2015 goal. Only 28 per cent of 0-14-year-old children living with HIV who were eligible for antiretroviral treatment under current guidelines were receiving it in 2011. HIV-positive pregnant women also lag behind the overall adult population in accessing lifesaving treatment. Offering treatment to pregnant women living with HIV preserves their own health, prevents vertical transmission and prevents transmission to sexual partners. In 2013, it was reported that the number of pregnant women receiving antiretroviral therapy rose more than sevenfold after Malawi implemented a policy of offering lifelong treatment to all HIV-positive pregnant and breastfeeding women. In 2012, the World Health Organization (WHO) published an update to 2010 guidelines which outlined the operational and programmatic benefits of making treatment available to all pregnant women living with HIV regardless of immune status.

38. Priority countries have developed costed national plans to eliminate mother-to-child transmission with support from the 28-member Inter-Agency Task Team on Prevention and Treatment of HIV Infection in Pregnant Women, Mothers and Their Children (IATT). That partnership, led by United Nations agencies, includes a broad array of civil society organizations and donors.

D. Reach 15 million people living with HIV with antiretroviral therapy

39. Expansion of access to antiretroviral therapy continues, with scaled-up treatment having added 14 million life-years in low- and middle-income countries since 1995, including 9 million in sub-Saharan Africa. For the first time, a majority (54 per cent in 2011) of individuals eligible for antiretroviral therapy are now receiving it. The number of countries achieving at least 80 per cent coverage rose from 7 in 2009 to 10 in 2011, while the number of countries with coverage below 20 per cent dropped from 28 to 10. Several factors have contributed to those

encouraging results, including continued declines in prices for antiretroviral medicines in low- and middle-income countries, an increase in the number of people living with HIV who know their HIV status, and enhanced efficiency of treatment programmes as a result of improved programme management, simplified drug regimens and the development of point-of-care diagnostic tools.

40. Still, gains are not equally shared, with persistently below-average coverage reported in West and Central Africa, Eastern Europe and Central Asia, and the Middle East and North Africa. Globally, treatment coverage for men is notably lower than for women, owing in part to differences in health-seeking behaviours. Late diagnosis continues to undermine treatment outcomes, many individuals who test HIV-positive are not linked to treatment and care, and surveys in parts of sub-Saharan Africa suggest that one third or more of people who initiate antiretroviral therapy are no longer in care five years later. Further reductions in the cost of antiretroviral drugs (especially the second- and third-line drugs that will be increasingly needed over time) will be required to accelerate and sustain treatment scale-up, underscoring the need for effective use of flexibilities available under international intellectual property rights provisions, continued availability of generic alternatives to branded drugs, and increasing capacity of African countries to manufacture essential medicines.

41. UNAIDS contributed to the extraordinary progress towards the 2015 target of 15 million people on antiretroviral therapy. The UNAIDS Strategy aims to radically simplify treatment. The International Drug Purchase Facility (UNITAID) is supporting efforts to shape markets to accelerate uptake of simplified and improved treatment regimens and point-of-care diagnostic technologies. Stakeholder meetings and country missions were convened to support treatment optimization in countries. Work was undertaken to update and consolidate antiretroviral treatment guidelines, which will be launched in 2013. UNAIDS assisted the Southern African Development Community Ministers of Health in developing a strategy for pooled procurement, and the Joint Programme assisted countries such as Uganda in exploring options under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) to enhance access to affordable essential medicines.

42. The Joint Programme is placing increased priority on actions to ensure achievement of the goal of universal access to treatment. UNAIDS provided extensive guidance and support to the African Union in the development of its Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa (2012-2015). A key element of the African Union Roadmap is the development of strong and sustainable capacity for pharmaceutical manufacturing in the region and the harmonization of regulatory systems for medicines to support local manufacturing and expedite access to important medical innovations.

E. Reduce tuberculosis deaths among people living with HIV by 50 per cent

43. Tuberculosis remains the leading cause of death for people living with HIV, although gains in addressing HIV/tuberculosis co-infection through collaborative programming saved an estimated 1.3 million lives from 2005 to 2011. As

antiretroviral therapy has been brought to scale, efforts to minimize tuberculosis have benefited, as HIV treatment reduces the risk of tuberculosis illness among people living with HIV by 65 per cent, regardless of CD4 count. In 2011, 69 per cent of all people with tuberculosis in sub-Saharan Africa (and 40 per cent globally) were tested for HIV, and 3.2 million people living with HIV were screened for tuberculosis, with 446,000 people living with HIV receiving isoniazid preventive therapy.

44. While testing rates have significantly improved in HIV and tuberculosis care settings, greater strides are needed to ensure that individuals with HIV/tuberculosis co-infection receive the services they need. Although the WHO Policy on Collaborative TB/HIV Activities: guidelines for national programmes and other stakeholders recommends that all tuberculosis patients living with HIV should receive antiretroviral therapy as soon as possible, regardless of CD4 count, only 48 per cent of people with both tuberculosis and a documented HIV-positive test result obtained antiretroviral therapy in 2011. A rise in multi-drug resistant tuberculosis in Eastern Europe and Central Asia, where HIV incidence is increasing, underscores the need to ensure an integrated response to the linked epidemics of HIV and tuberculosis.

45. The Joint Programme undertook numerous measures, including market interventions, technical support and assistance through the Global Drug Facility, to expedite uptake of the Xpert MDR/RIF diagnostic technology for multi-drug-resistant tuberculosis. In 2012 in Africa, the Global Drug Facility provided first-line drugs to 18 countries, treatments for multi-drug-resistant tuberculosis to six countries, and diagnostic technologies to 11 countries. A road map was developed for implementation of priority tuberculosis interventions among children, and nutritional support was provided to improve tuberculosis outcomes in 10 countries. With technical support, 119 countries tested over 50 per cent of tuberculosis patients for HIV. Efforts by the Joint Programme supported the harmonization of data and strengthening of tuberculosis monitoring and evaluation systems, reflected in the publication by WHO in 2012 of comprehensive strategic information on tuberculosis and HIV.

F. Close the global AIDS resource gap

46. In 2011, total resources of US$ 16.8 billion were available for HIV-related activities worldwide. For the first time, domestic resources (including both public and private sectors) accounted for a majority of global HIV-related spending, investing US$ 8.6 billion in 2011, more than double the amount invested by low- and middle-income countries in 2005. The historic increase in domestic spending on HIV was facilitated and supported, in part, by consistent and high-level advocacy by UNAIDS, based on the premise that the AIDS response is a shared responsibility that demands leadership, commitment and sacrifice from all stakeholders. Although national investments have grown, international donors remain critical to a well-financed response; disbursements by members of the Organization for Economic Cooperation and Development rose by 10 per cent in 2011.

47. While redoubling efforts to mobilize sufficient resources for the response, work has also intensified to enhance the strategic focus and impact of finite financing. With the aims of maximizing the number of averted new HIV infections

and AIDS-related deaths and lowering the long-term cost curve for the response, UNAIDS has outlined an investment approach that combines scale-up of basic programmatic activities, support for critical enablers that enhance the reach and effectiveness of programmes, and focused financing to capture synergies with broader development efforts. In 2013, 29 countries were moving forward with UNAIDS assistance to implement an investment approach. Civil society partners worldwide have actively advocated for adoption of an investment approach. Major donors have also taken steps to enhance the strategic focus of their efforts. The United States President's Emergency Plan for AIDS Relief, the largest bilateral funder of HIV activities in low- and middle-income countries, unveiled a strategic blueprint to accelerate progress towards an AIDS-free generation. In 2013, the Global Fund launched a new funding model that prioritizes assistance to the most heavily affected countries and focuses funding on interventions with the greatest public health impact.

48. Nevertheless, a major resource gap remains. Total annual resources of US$ 22 to 24 billion will be needed by 2015 to lay the foundation for the end of the epidemic. Mobilizing the resources needed is a shared responsibility. Although low- and middle-income countries overall have increased domestic funding for the response, many countries still fail to invest resources commensurate with their economic status and national HIV burden. Inequities in financing also persist, with few national resources focused on programmes for key populations. HIV funding for women also overwhelmingly focuses on prevention of new infections in children, with limited support for programmes that address women's many other prevention and treatment needs, including but not limited to sexual and reproductive health services.

49. To help close the resource gap, UNAIDS published comprehensive data on HIV spending patterns in 2012 and analysed the potential impact of increased domestic allocations for HIV in Africa. Guidance to countries to implement investment approaches was developed and disseminated by UNAIDS. Regional joint teams aided countries in assessing their eligibility under the Transitional Funding Mechanism of the Global Fund.

G. Meet the specific needs of women and girls, and eliminate gender inequalities and gender-based abuse and violence

50. Women and girls face a disproportionate burden of the epidemic. Young women aged 15 to 24 years are particularly vulnerable, accounting for 22 per cent of all new HIV infections globally. Although it is well recognized that unequal gender norms increase women and girls' vulnerability to HIV and exacerbate burdens on women and girls living with HIV, attention to gender inequality in the context of AIDS responses remains insufficient. For example, in 2012, only one quarter of countries had made female condoms available to all women. Similarly, gender-based violence remains inadequately addressed as a driver of women's vulnerability to HIV.

51. In response to the above-mentioned challenges, the UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV calls for concerted efforts to help countries to address the needs and rights of women and girls, and eliminate gender inequalities, in the context of HIV. The UNAIDS Agenda

has been operationalized in approximately 100 countries since its launching in 2010. A 2012 external review found that 60 per cent of countries that have launched the Agenda have demonstrated measurable progress in strengthening their evidence base, translating political commitments into scaled-up services, and creating an enabling environment for the HIV-related needs and rights of women and girls. Notable achievements under the UNAIDS Agenda include the systematic collection of data on intimate partner violence. In addition, with the support of UNAIDS and other partners, three quarters of countries link HIV and sexual and reproductive health services. In more than two thirds of countries, women living with HIV are now regularly engaged in formal planning and review mechanisms of the national response.

52. In line with the Secretary-General's UNiTE to End Violence against Women campaign, UNAIDS has played a leadership role in raising awareness of the links between HIV and sexual and gender-based violence and in advocating for effective action to prevent such violence. Five United Nations agencies, the United States Government and the private sector have joined together in Together for Girls, a partnership that works with nine countries to build the evidence base on violence against girls and other children and supports multisectoral action to address the problem. In addition, Executive Director of UNAIDS, Michel Sidibé, and the former Archbishop of Canterbury, Rowan Williams, launched the We Will Speak Out Coalition in March 2011 to partner with churches to address sexual and gender-based violence, launching collaborative work in five countries.

53. Despite the progress described, significant challenges remain. Work on gender equality and HIV remains under-resourced, and questions persist regarding the sustainability of recent momentum to address the needs and rights of women and girls in the context of HIV through a comprehensive approach that strengthens advocacy, evidence, service delivery and accountability for gender-transformative HIV responses.

H. Eliminate stigma and discrimination and reduce punitive laws against people living with or vulnerable to HIV

54. Stigma and discrimination, as well as punitive laws and policies, against people living with or vulnerable to HIV continue to hinder efforts to implement sound, evidence-informed and human rights-based responses. According to data collected through the People Living with HIV Stigma Index, stigmatizing attitudes towards, and mistreatment of, people living with HIV remains widespread. Research findings indicate that substantial percentages of people living with HIV have experienced verbal and physical abuse, social ostracism, job loss and emotional distress. The evidence indicates that those most vulnerable, such as key populations, including migrant populations, are more likely to be verbally insulted or physically assaulted, to lose employment and to experience shame than the general population. Discrimination undermines effective responses by denying or diminishing the quality of services for people living with or at risk of HIV. Meanwhile, stigma is deterring people from accessing the services they need, reduces the willingness to disclose one's HIV infection to partners, and blunts efforts to mobilize diverse stakeholders to respond with solidarity and compassion to HIV.

55. The Global Commission on HIV and the Law, an independent commission supported by the Joint Programme, recommended that countries explicitly bar HIV-related discrimination; refrain from criminalizing HIV exposure, non-disclosure or transmission; implement specific protections for women and girls; pursue legal measures to increase treatment access; and remove punitive or discriminatory laws and policies regarding key populations and vulnerable groups. Notwithstanding the urgent need to take effective action to eliminate stigma and discrimination, nearly 4 in 10 countries in 2012 reported having no specific legal provisions to prevent or address HIV-related discrimination, and 45 per cent of countries had no legal services in place to assist those who experience such discrimination to pursue their rights. At least 60 per cent of countries have laws, regulations and policies that present obstacles to effective prevention, treatment, care and support for key populations, and about 60 countries have adopted laws that specifically criminalize HIV transmission. Most countries have laws in place that deem aspects of sex work to be illegal; punitive approaches to drug use are widespread, and more than 40 per cent of the States Members of the United Nations criminalize same-sex sexual relations.

56. UNAIDS has been an advocate for the health and human rights of men who have sex with men and transgender people. UNAIDS calls have been supported by strong statements by the Secretary-General of the United Nations and the United Nations High Commissioner for Human Rights.

57. Through the Unified Budget, Results and Accountability Framework, UNAIDS has intensified its efforts to eliminate stigma and discrimination and promote national responses that are grounded in human rights and that implement programmes to support those rights. UNAIDS developed a guidance note on programmes to reduce stigma and discrimination and ensure access to justice in the context of HIV, as well as a human rights costing tool to inform HIV-relevant human rights programmes. The Joint Programme provided objective evidence of the impact of punitive laws, policies and practices on HIV and health outcomes. UNAIDS supported action on HIV and the law in 73 countries, including 31 countries identified by UNAIDS as high-impact. Reviews of the legal environment were supported in 51 countries (including 18 high-impact countries), and national dialogues resulted in the development of 16 national and 21 sectoral workplace policies on HIV. In partnership with the Global Network of People Living with HIV (GNP+) and the International Community of Women Living with HIV/AIDS, UNAIDS supported 36 countries to finalize and report on their research for the People Living with HIV Stigma Index, with similar efforts under way in 34 additional countries. UNAIDS issued a joint statement involving 11 United Nations system agencies calling for the closure of compulsory drug detention and rehabilitation centres for sex workers. UNAIDS provides ongoing assistance to the Global Fund on development of the human rights aspects of the Fund's new strategic plan and its implementation under the new funding model.

I. Eliminate HIV-related restrictions on entry, stay and residence

58. A welcome trend is apparent with regard to HIV-related restrictions on entry, stay and residence. The number of countries and territories with such restrictions fell from 96 in 2000 to 44 in 2013. Countries are increasingly recognizing that such laws are discriminatory and lack any public health justification. Despite this

encouraging trend, 44 countries and territories still deny equal freedom of movement of people living with HIV based solely on their HIV status. Among other things, such restrictions may also involve mandatory HIV testing, summary deportation and denial of asylum.

59. In support of efforts to eliminate HIV-related restrictions on entry, stay and residence, UNAIDS continues to monitor the number of countries with such restrictions in place, encouraging those with such restrictions to repeal them, and supporting national coalitions to work for their removal. The Joint Programme supported the recent elimination of travel restrictions in Mongolia, the Republic of Korea and the Republic of Moldova. In 2012, UNAIDS, in partnership with GBCHealth, mobilized more than 40 global corporate chief executive officers to sign a pledge opposing HIV-related entry, stay and residence restrictions, urging repeal of such laws as unnecessary burdens on the ability of businesses to send human resources where they are most needed.

J. Eliminate parallel systems for HIV-related services to strengthen integration of the AIDS response

60. The AIDS response both contributes to the broader development agenda and benefits from gains across the full breadth of the Millennium Development Goals. Recognizing the interdependent links between AIDS and the broader development advances, the 2011 Political Declaration called for concerted efforts to link the AIDS response more closely with the broader development, health and human rights agenda.

61. Substantial integration of HIV with other health and development initiatives is apparent, both within and beyond health systems. As a comprehensive review of the United States President's Emergency Plan for AIDS Relief recently found, HIV programmes have yielded substantial health benefits beyond HIV, increasing life expectancy, reducing tuberculosis incidence and mortality and strengthening health systems. Tuberculosis and HIV services have been closely integrated in many settings, services to prevent children from acquiring HIV have been situated in maternal and child health services, and the Pink Ribbon Red Ribbon (jointly launched by the George W. Bush Institute, the President's Emergency Plan for AIDS Relief, Susan G. Komen for the Cure and UNAIDS) is working to expand HIV, cervical and breast cancer screening and treatment for women in sub-Saharan Africa and Latin America. HIV interventions have been integrated broadly across all aspects of humanitarian operations, prevention services for HIV and gender-based violence have been linked in conflict and post-conflict settings, and numerous countries have worked to integrate HIV interventions in broader social protection systems.

62. Using core funds from the Unified Budget, Results and Accountability Framework, UNAIDS has developed tools and processes to enable countries to create incentives to eliminate parallel systems through optimal design of HIV responses. A project to promote linkage of HIV and sexual and reproductive health services has proven effective in all countries where it has been implemented (Botswana, Lesotho, Malawi, Namibia, Swaziland, Zambia and Zimbabwe). Funding from the World Bank was leveraged to assist countries in enhancing service

integration, and assistance was provided to 15 countries with broader maternal and child health systems to integrate prevention of new infections in children.

IV. Recommendations to accelerate progress towards achievement of the 2015 targets and commitments

63. **The Economic and Social Council may wish to consider the following actions:**

(a) **Acknowledge that while historic progress has been made in preventing new infections among adults, adolescents and young people, advancing towards the goal of eliminating new infections among children and keeping their mothers alive, and delivering life-saving treatments to people living with HIV, the AIDS epidemic is not over, demanding a renewed commitment to strengthened shared responsibility and global solidarity to lay a firm foundation for ending the AIDS epidemic. Given that Millennium Development Goal 6 remains unfulfilled, it is critical that the post-2015 development agenda include clear, prioritized, time-bound targets to accelerate progress towards an AIDS-free generation;**

(b) **Commend the support provided by the Joint United Nations Programme on HIV/AIDS (UNAIDS) to progress made towards achieving universal access to HIV prevention, treatment, care and support, including the assistance to countries in reporting on the progress to the General Assembly, resulting in a record 186 country reports, providing the most comprehensive overview to date of the response at the country level;**

(c) **Acknowledge the close links between HIV and other global health and development objectives, underscoring the need for integration of HIV with other global movements and development initiatives at the level of strategic planning, service delivery, and monitoring and evaluation. The AIDS response provides important lessons for leveraging and strengthening the broader health, development, human rights and gender equality goals and agendas, including its results-based focus, people-centred approach, and reliance on the passionate commitment of multisectoral stakeholders, including civil society and people living with HIV;**

(d) **Recognize that the Joint Programme offers a useful example of an innovative mechanism to enhance the strategic coherence, coordination, results-based focus and country-level impact of efforts by the United Nations to address difficult health and development challenges in line with and supporting General Assembly resolution 67/226 on the quadrennial comprehensive policy review of operational activities for development of the United Nations system;**

(e) **Note the continuing need to ground the AIDS response in human rights and gender equality, and to fully engage young people in the AIDS response, including their access to sexual and reproductive health services and comprehensive sexuality education;**

(f) **Noting the need to close the AIDS resource gap, encourage countries to scale up their domestic funding for the response and appeal to international donors to renew their commitment and solidarity in the response, including**

taking steps to ensure full and robust funding for the Global Fund to Fight AIDS, Tuberculosis and Malaria. At the same time as renewed efforts focus on mobilizing essential new resources, comparable attention must concentrate on ensuring value for money in the AIDS response, through measures to improve service efficiency and effectiveness, aligning national responses with documented epidemiological patterns and national needs, and implementing sound investments.